

# Department of Public Health

## **Transition Team Office of Child Protection**

**September 22, 2014**



# Home Visitation Services in Los Angeles County

Two MIECHV\* accepted Evidence Based Home Visitation Models overseen by the Department of Public Health:

- Healthy Families America
- Nurse Family Partnership

\*Maternal, Infant and Early Childhood Home Visiting – Federal grant funding requires 75% of funded program models to be proven and effective



# Expected Outcomes for HV Programs

- Improved maternal and child health;
- **Prevention of child injuries, child abuse, or maltreatment;**
- Reduction of emergency department visits;
- Improvement in school readiness and achievement;
- Reduction in crime or domestic violence;
- Improvements in family economic self-sufficiency;
- Improvements in parenting skills related to child development; and
- Improvements in the coordination and referrals for other community resources and supports.



# What is a High Risk Mother?

- Living in poverty
- Pregnant for the first time
- Young age (less than 21)
- Known Intimate Partner Violence (IPV) in the home or outside the home
- History of abuse/neglect as a child
- History of foster care involvement as a child
- History of criminal involvement (gang involvement, incarcerated previously)
- History of drug use/abuse



# What is a High Risk Mother

- Other children removed from her care and now in protective services
- Psychologically impaired (witness trauma, depressed, early onset mental disease)
- Developmentally disabled
- Living with stressed families (living with gangs, multi-family dwellings, mental illness or drug use in the home)
- Lack of prenatal care (when resources available)
- Medically high risk (genetic issues, prematurity history, previous fetal demise)



# How are high risk moms identified?

- Varies by the program offering services:
- Outreach to prenatal clinics, hospitals, physicians, WIC centers, child advocate resources like the Alliance for Children's Rights (foster children), CMS (disabled), and the schools (for those they can't serve or who will be graduating in less than 2 years.)
- Hospitals identify medically (via blood test results, problems with fetal development, obvious signs of abuse, etc.)
- Some home visiting programs do screening initially upon phone intake to refer to specialized resources – relationship building is important for client to disclose



# Pregnant Teens and Substance Abuse Treatment

- Approximately 8-10 % of NFP clients are found to have a drug/alcohol program,
- Clients in the NFP program are referred to their neighborhood drug/alcohol counseling center when identified as having an issue with drugs/alcohol
- Many NFP clients have stopped “cold turkey” when they found out they are pregnant, but their chances of relapse are high following the baby’s birth
- Many schools (like LAUSD) run their own substance abuse peer support groups and counseling



# Evidenced-Based and Culturally Appropriate Referral Resources and Services

- No current process set up to systematically identify or rank “evidence-based” or culturally appropriate referral resource programs
- PEER school based counseling has better objective outcomes than traditional counseling for teen drug and alcohol issues.
- Hard to find culturally appropriate (and trained) mental health services for pregnant women and even more difficult to find mental health services for pregnant youth with drug and alcohol issues.
- Biggest barrier: Client will not go to counseling for the same reasons they won’t go to mental health treatment—transportation, stigma, fear, etc.



# Access to Substance Abuse Services for High Risk Parents and Caregivers- DPH Project

- 14 Community-based agencies providing residential and outpatient services to adults (aged 18 and over).
- Target population is pregnant women and parents/caregivers of children aged 0-5 years who have an open DCFS case.
- Co-locate a substance abuse navigator at DCFS Regional offices to provide screening, brief intervention, and referral to treatment services
- The co-located navigators refer teens (parents under the age of 18) to a youth treatment service provider. The contracted residential agencies are not able to accommodate a parent under the age of 18.



# Health Care Program for Children in Foster Care: Public Health Nurses (PHN)

- Coordinate medical, dental and mental health care
- Coordinate health services for children in out-of-county and out-of-state placements
- Expedite referrals for medical, dental, mental health and developmental services
- Provide medical education and training for Foster Care team members, Probation Officers, Judges, School Nurses and Caregivers on the special health care needs of children and youth in foster care
- Assist Children's Social Workers to interpret medical report and medical findings.
- Assist foster caregivers to obtain timely comprehensive health assessments and dental examination.



# Public Health Nursing Serving Children and Youth involved in the Child Protective System

- Public Health Nurses (PHNs) assist the DCFS Children's Social Worker (CSWs) to promote health, prevent disease, and facilitate the provision of health care services allowing children to reach their optimal level of health.
- Both DCFS and DPH have Public Health Nurses serving children and youth involved in the child protective system. DPH PHNs serve children and youth that have been removed from their homes through the Health Care Program for Children in Foster Care.
- Public Health Nurses, located in DCFS offices, are available to assist the DCFS Children's Social Workers in ensuring that children receive proper medical care, assessment, and to aid in cases that require medical consultation.



# Gaps and Opportunities

- Distinct Programs within and across departments
- Programs limited by Eligibility Requirements (age, health status, pregnancy age, child's age, geographic locations, etc.) AND Funding source (target population, service type, geographic coverage)
- Need for Additional Training: Medical Providers, Mental Health Providers, Public Health Nurses
- Lack of training for school personnel, what to do when...
- Lack of Community Awareness what to do when...
- DCFS and DPH PHNs awareness of available resources to which they may refer Children's Social Workers (CSW) and families and monitoring referral compliance and outcomes.
- The DMH should strengthen their collaborations for innovative methods to treat co-occurring issues with drugs and mental illness especially with pregnant and post partum clients.



# Activities and Suggestions

- Inventory existing programs/services
- Determine the quality of the program/services
- Look for opportunities to expand successful programs/services
- Utilize resources that work well; e.g. schools to share their PEER support group counseling data
- Think strategically with representatives from each department or external committee/consortium and stakeholder to design, develop, fund and initiate this plan
- Example of past interdepartmental coordination: Interagency Operations Group (IOG); Los Angeles County Alcohol and Other Drug Affected Parent Task Force.



# One Example: Countywide Home Visiting Consortium

- Coordination of the Countywide effort to refer clients to the appropriate HV Program
- Every new or at-risk pregnant woman/youth will have access to the highest quality in-home support they need (preferably beginning before the birth of their first child) and delivered by well trained individuals in order to achieve healthy birth outcomes, promote ongoing child safety and development, and strengthen family functioning and self-sufficiency.



# Questions?

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